VITAS®
INNOVATIVE HOSPICE CARE®
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October 23, 2006

Linda Cole, Chief
Long Term Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Cole:

On behalf of VITAS Healthcare Corporation, thank you for the opportunity to comment on the draft update to *COMAR 10.24.08 State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services*. VITAS Healthcare Corporation (VITAS) is the nation's largest full-service provider of hospice care. In this letter, we provide comments on sections .12 to .15 of COMAR 10.24.08 concerning hospice services, CON docketing rules for hospice, hospice standards, and the methodology for projecting need for hospice services.

Background on VITAS

VITAS is a multi-site hospice company serving more than 11,000 hospice patients each day. VITAS programs served more than 50,000 patients during 2005, and more than 675,000 since its founding in 1978. VITAS currently operates 42 programs in 17 states across the country, employing more than 8,700 healthcare workers and professionals.

As one of the nation's first hospices, VITAS took a leadership role in defining and setting standards for quality hospice care and has developed processes and technology, now industry standards, to enhance quality of life for the terminally ill. More than ten years ago, VITAS developed a proprietary information management system, VITAS Exchange (Vx), that provides real-time communication of patient information and supports the efficient delivery of high-quality services to patients in disparate locations, and in the last three years VITAS has developed a complete electronic patient record for use at the bedside.

VITAS was a founding member of the National Hospice and Palliative Care Organization (NHPCO), and helped develop the standards of care used throughout the United States by other hospice programs. Bob Miller, Senior Vice President of Clinical Development and Ethics for VITAS, serves as Chair of the National Council of Hospice and Palliative Professionals which places him on the NHPCO Board of Directors.

To enhance access to and quality of hospice care, VITAS is committed to supporting and conducting both clinical and health services research. VITAS has collected utilization and outcome data on patients since 1995 and through partnerships with respected academic researchers, these data have been used in several published health services research studies.

VITAS is particularly concerned with all elements of the proposed plan that affect access to hospice. VITAS cares for adult and pediatric patients with a wide range of life-limiting illnesses, including but not limited to: cancer; heart disease; stroke; lung, liver and kidney disease; multiple sclerosis; ALS; Alzheimer's and AIDS. In fact, in 1988, VITAS launched the first AIDS-specific hospice program in the country.

VITAS is committed to expanding access for traditionally underserved populations, particularly communities of color, the economically disadvantaged and those with non-cancer diagnoses including AIDS. Non-white populations are traditionally underserved for hospice.[1] VITAS has been successful in using specific strategies for serving inner city communities of color, notably in Chicago where it operates a program in collaboration with Rainbow/PUSH Coalition's *One Thousand Churches Connected.* This unique partnership fosters initiatives that promote hospice particularly in underserved areas. In addition, all VITAS caregivers are trained on how to care for persons of varying cultures and religions through the "Things Hospice Innovators Need to Know" (THINK) program developed to train VITAS employees and volunteers on diversity issues and how to approach individuals of various cultures and faiths such as African Americans, Euro-Americans, Hispanic/Latino Americans, Jewish Americans and Muslim Americans. VITAS was recently presented with an award by the Initiative to Improve Palliative Care for African Americans for demonstrated commitment to providing and improving quality end-of-life services for African American communities. In addition, VITAS has demonstrated a strong commitment to providing charity care from its beginning days when all patients were cared for solely depending on donations and volunteers. Year after year, VITAS provides in excess of one percent of revenues in charity care. For fiscal year 2005, this amount exceeded $9.0 million.

Comments on Sections .12 to .15

VITAS commends the commission for several changes/additions to COMAR 10.08.24 that may lead to increased access to hospice services including:

- NEW policy 10.0 to monitor national data to determine the need for pediatric hospice;
- Changes to the methodology for calculation of need so that projected need will no longer be based primarily on cancer deaths with a specified limit to the projected percentage of non-cancer deaths to be served; and
- NEW policies 11.0 and 11.1 directing the commission to continue to collect data from hospice programs and to examine how need is calculated and assess whether

[1] O'Mara, AM and Arenella, C (2001) J. Pain and Symptom Manage. 21(4):290-7.; Greiner, KA, Perera, S and Ahluwalia, JS (2003) J Am Geriatric Soc 51(7):970-8.

revisions should be made to adjust for changes in the health care system or other factors affecting need.

In addition, the proposed new methodology for calculating need has some laudable features including:

- The use of non-accidental deaths as the potential target population for hospice services;
- Calculation of the annual expected growth rate for hospice deaths and the hospice death multiplier;
- Adjustment of the hospice death rates to the state average in jurisdictions where the current use rate is below the state average; and
- The use of different volume thresholds for urban and rural jurisdictions.

In the spirit of Policy 11.1, however, we would like to point out some concerns and some apparent inconsistencies in the newly proposed methodology.

Concerns with the proposed methodology for projecting need for hospice services

The proposed methodology addresses projected need but fails to address the possibility that there is current unmet need for hospice services in the state. One of the assumptions for the need calculation methodology is that all hospice utilization is appropriate. Although not stated, we assume this means all *current* hospice utilization is appropriate since the methodology bases future need on current use. However, by basing future need on current use plus a calculated growth factor, the methodology assumes that there is no current unmet need and perpetuates any existing inequities inherent in that assumption. The proposed methodology for projecting need thereby ignores the possibility of current/existing unmet need for hospice services. Adjustment of hospice death rates in counties where the rate is lower than the state average up to the current state average addresses this concern only in part. The adjustment strategy also assumes that the current state average for the hospice death rate is adequate, failing to recognize the possibility that some counties may be currently underserved for hospice.

In fact, based on our experience serving patients in more than 165 counties nationally and our studies of market penetration in several other communities, we believe that there is current unmet need for hospice services in Maryland. The 2004 data reported in Supplement 1 to COMAR 10.24.08 shows that Maryland hospices currently serve 33% of all deaths in the state. Hospice experts have estimated that up to two-thirds (66%) of all deaths will require end-of-life services; the model excludes one-third of deaths nationally where there is no end-stage including those where death is sudden, after a short course of illness, or unpredictable (such as accidents.)[2]

VITAS reviewed 2003 patient volumes and ADC (assuming 60 day ALOS, a national statistic reported by NHPCO) for over 1900 counties in the United States to see how many were serving at least 50% of all deaths. The following summarizes our method of assessment:

- We estimated the maximum expected ADC (average daily census) for over 1900 counties in the US assuming the following: use of hospice services by 50% of all deaths with an average length of stay of 60 days (a national statistic reported by the

2 Connor, SR (1999) The Hospice Journal, 14(3/4), 193-203.

National Hospice and Palliative Care Organization). [(Total deaths X 50% X60 days)/365 days]

- Using data from the Centers for Medicare and Medicaid Services (CMS)[3], we calculated the actual ADC being served in the same counties (assuming the national 60 day ALOS). [Total patients served X 60 days/365 days]

We find that 207 counties are reaching or exceeding the calculated maximum ADC, and an additional 350 counties are reaching half of the calculated maximum; and these numbers are conservative since only Medicare hospice use is counted. In many if these counties, more than 50% of deaths are attributable to "typical" hospice diagnoses including cancer, heart disease, end-stage lung disease, dementia, and AIDS. Furthermore, the counties reaching penetration rates of 50% or more include jurisdictions with a wide range of non-white population percentages and economic levels. These data demonstrate that a projected penetration rate of at least 50% of deaths is reasonable for most counties in the US.

We applied a similar method to assess current need for hospice services in Maryland. Using the 2004 ALOS of 53 days and current volume hospice patients served as reported in Supplement 1 to COMAR 10.24.08 (pg. 46), only one county, Cecil, currently serves 50% or more deaths, and only two counties, Carol and Baltimore (County) serve more than 40% of deaths. The statewide rate of hospice usage for all counties is 33% of all deaths. (See Table 1) These data suggest that there is current unmet need in all but one Maryland county. This current unmet need would not be addressed by the proposed methodology for projecting need for hospice services.

VITAS is particularly concerned that the current unmet need is concentrated in urban areas with high non-white populations. Using an ALOS of 53 days and the current volume of hospice patients served, three counties show an existing potential unmet need of more than 100 patients per day; they are Baltimore City, Montgomery, and Prince George's Counties. These are 68.4%, 35.2% and 73% non-white, respectively. Two of these, Prince George's and Baltimore City (both with higher projected unmet hospice needs) also have higher rates of poverty and lower household incomes than the state average. Note that Prince George's is the only one of these three counties demonstrating future need using the proposed methodology.

Based on this reasoning, we suggest that in addition to the projected need identified in two counties there is current unmet need for hospice services in all but one county. We further suggest that the proposed methodology be revised to account for both current unmet need and projected need.

Inconsistencies in the proposed methodology for projecting need for hospice services

VITAS would like to point out the following apparent inconsistencies in the proposed calculation for projecting need:

- Both sections .15A(2) and 15H(1) [as well as the definitions in section .15I(1)] refer to non-accidental deaths for the total 65+ population. This is inconsistent with the

[3] Although CMS data includes only Medicare patients, 80% of hospice patient days are paid by Medicare (NHPCO Dataset, 2001).

statement in section .15D that "Projections are made for all age groups." [Note that the summary of changes document states that this section should read "...for all age groups combined" but that is not the way the draft document is worded.]

- It appears that there is an inconsistency in sections .15H(1), .15H(5), .15I(1) and .15I(6) where the calculations refer to all deaths (for all age groups), but use the population figure for 65+ only.

- The calculations for the hospice death rate in .15H(2) and .15I(2) use all hospice deaths; this would also be inconsistent with the use of a population death rate for 65+ only.

We respectfully request clarification of these inconsistencies.

Apparent Errata

Finally, we note the following apparent errors in the proposed document:

- Calvert and Charles counties are missing from the list of urban and rural counties in section .15I(1). They do not appear in either list.

- Section .15H (b) does not appear. There are references within Section .15H to both sections (a) and (b) but neither is designated within the document. The description of the volume threshold appears to be missing.

- In Section .15H(3), the description of the calculation of the growth rate for hospice deaths incorrectly calls for subtraction of base year deaths from the number of deaths two years prior; the equation in Section .15I(4) correctly shows subtraction of the number of deaths two years prior to the base year from the number in the base year.

VITAS is grateful for the opportunity to comment on the draft update to *COMAR 10.24.08 State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services*. We would welcome the opportunity to discuss these comments with members or staff of the commission. You may reach us by contacting VITAS Senior Vice President, Ron Fried, or me at (305) 350-5936.

Sincerely,

Deirdre Lawe

Deirdre Lawe
Executive Vice President, Strategic Development and Public Affairs
VITAS Healthcare Corporation

Table 1: Maryland - Estimated current need for hospice services based on percentage of all deaths by county

Designated rural counties

	Actual Data - 2004					Current and possible ADC - Use ALOS = 53 days*			
	Deaths	Non Accidental Deaths	Hospice Patients Served	%deaths served in hospice		Current ADC served	Possible ADC; based on 40% deaths	Possible ADC; based on 50% deaths	Current unmet need; ADC based on serving 50% of deaths
Allegany	930	904	209	22%	✓	30	54	68	37
Anne Arundel	3665	3558	1328	36%	✓	193	213	266	73
Baltimore County	7784	7585	3586	46%	✓	521	452	565	44
Baltimore City	7221	7044	1891	26%	✱	275	419	524	250
Calvert	606	582	203	33%	✓	29	35	44	15
Caroline	296	286	94	32%	✓	14	17	21	8
Carroll	1284	1238	550	43%	✓	80	75	93	13
Cecil	722	691	398	55%	▪	58	42	52	-5
Charles	856	810	234	27%	✓	34	50	62	28
Dorchester	386	375	56	15%	✓	8	22	28	20
Frederick	1450	1399	491	34%	✓	71	84	105	34
Garrett	307	294	99	32%	✓	14	18	22	8
Harford	1708	1656	557	33%	✓	81	99	124	43
Howard	1328	1293	473	36%	✓	69	77	96	28
Kent	204	198	56	27%	✓	8	12	15	7
Montgomery	5448	5337	1912	35%	✱	278	316	396	118
Prince George's	5119	4882	1083	21%	✱	157	297	372	214
Queen Anne's	366	353	108	30%	✓	16	21	27	11
St. Mary's	679	652	237	35%	✓	34	39	49	15
Somerset	232	227	63	27%	✓	9	13	17	8
Talbot	440	426	161	37%	✓	23	26	32	9
Washington	1367	1321	507	37%	✓	74	79	99	26
Wicomico	854	827	212	25%	✓	31	50	62	31
Worcester	516	505	142	28%	✓	21	30	37	17
ALL COUNTIES	43768	42443	14650	33%		2127	2542	3178	1050
ALL COUNTIES	43768	If 40%	17506	40%	✓				
ALL COUNTIES	43768	If 50%	21886	50%	✱				

* From the Maryland Hospice Network Survey; Reported in Supplement 1: COMAR 10.24.08

✓ Denotes counties with current unmet need for hospice care

✱ Denotes counties where unmet need (ADC, assuming 50% of deaths can be served) is at least 100 patients more than current ADC